DOCUMENT RESUME

ED 426 531 EC 306 964

TITLE	The Juvenile Justice System. Chapter 6.
PUB DATE	1996-00-00
NOTE	18p.; In: A System of Care of Children's Mental Health: Expanding the Research Base. Proceedings of the Annual Research Conference (8th, Tampa, FL, 1996); see EC 306 958.
AVAILABLE FROM	Web site: http://lumpy.fmhi.usf.edu/CFSroot/rtc/proceeding8th
PUB TYPE	Reports - Descriptive (141) -- Speeches/Meeting Papers (150)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	Adolescents; *Behavior Disorders; Delinquency; *Delivery Systems; Elementary Secondary Education; *Emotional Disturbances; *Juvenile Justice; Mental Disorders; *Mental Health

ABSTRACT

This collection of papers presented at a 1996 conference on children's mental health focuses on the juvenile justice system. Papers have the following titles and authors: (1) "Delinquency and Mental Illness: The Intersection of Problems and Systems" (Carolyn S. Breda); (2) "Assessing the Mental Health of Adolescents in the Mental Health and Juvenile Justice Systems" (Jane Timmons-Mitchell and others); (3) "Psychopathology and Symptomatology in Incarcerated versus Hospitalized Youth" (Andres J. Pumariega and others); and (4) "Boot Camp: Is It Working?" (Judy A. Hall). (Individual papers contain references.) (DB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 426 531

8th Annual Children's Mental Health Research Conference Proceedings. Chapter 6. The Juvenile Justice System.

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

EC 306964

BEST COPY AVAILABLE

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Delinquency and Mental Illness: The Intersection of Problems and Systems

Authors

Introduction Method Results Discussion References

Return to Table of Contents

Introduction

The complexity of the emotional and behavioral problems youth experience thwart efforts to develop integrated and coordinated systems of care for children and adolescents (Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993). The difficulties of helping youth with multiple problems may be compounded when the problem set includes behaviors that span the mental health system and the juvenile justice system, specifically. Studies of the general population of adolescents show delinquency and mental disorder co-occur (e.g., Elliott, Huizinga, & Menard, 1989). Few studies, though, have estimated the proportion of youth referred to juvenile courts in need of mental health services or the proportion of mentally disordered juvenile offenders in mental health placements (Fagan, 1991). This summary explores (1) the prevalence of delinquency among youth referred for services within the mental health system, (2) the co-occurrence of delinquency and mental disorder, and (3) the prevalence of official delinquency as indicated by involvement with the juvenile justice system.

Return to Top

Method

Sample

Data were obtained through the Fort Bragg Evaluation Project (FBEP), an evaluation of a model mental health service system for children and adolescents (see Bickman, Guthrie, Foster, Lambert, Summerfelt, Breda, & Heflinger, 1995, for more details on the evaluation and the model service system). The sample included children and adolescents ages five through seventeen who were referred for formal mental health services at the time they entered the study. On average, youth were about 11 years old, and about 60% were male. Seventy percent were white; about 20% African American; and 10% were of other or mixed race/ethnicity. Less than half of the sample lived with both biological parents, though 80% lived in a two-parent household (e.g., with a biological and stepparent). Most of the families earned between twenty and forty thousand dollars annually. The sample's average standardized scores on the Child Behavior Checklist (CBCL) and Youth Self Report (YSR) were very similar to those reported by Achenbach (1991) and Achenbach and Edelbrock (1993) for other clinical samples of youth. Thus, findings from this research may apply to other populations of roughly middle-class youth referred for mental health services (see Bickman, et al., 1995, for more details on the representativeness of the sample).

Measures

Delinquency. The CBCL's (Achenbach, 1991) standardized narrow-band scale score on the delinquency syndrome measures level of delinquency-related problems1. Cutoff points for the scale also indicate whether youth fell into the borderline/clinical range (hereafter, clinical), or the nonclinical range. Official delinquency refers to contact with the juvenile justice system; that is, whether youth either had been picked up or arrested by police, punished or adjudicated by a court, placed on probation, or incarcerated.

Mental Disorder/Psychopathology. Seven standardized CBCL scales-p;withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, and sexual problems-p;measure level of psychopathology2. Again, cutoff points for each of the seven scales indicate whether youth fell into the clinical or nonclinical range for each problem area. An overall psychopathology measure identifies youth who fell into the clinical range for any of the seven syndromes.
Return to Top

Results

Delinquency
Table 1 shows the sample's average T-score on the delinquency syndrome was 64.4. Forty-seven percent of the youth fell into the clinical range. Nearly one-fifth (18%) of the youth had contact with the juvenile justice system, a rate roughly six times that found in the general population (U.S. Department of Justice, 1991). As expected, age and delinquency positively correlated, with regard to delinquent symptomatology and official delinquency. Particularly, delinquency and legal contact increased dramatically among older adolescents 12 to 17 years of age. Males also were significantly more likely than females to have had contact with the police or courts. Contrary to the delinquency literature (e.g., Elliott, et al., 1989), however, they showed lower levels of delinquency-related problems than females. African Americans, too, showed lower levels of delinquency than either Whites or youth of other races. These findings may reflect a selection bias, in that more seriously delinquent males and African Americans may be less likely to receive services within the mental health system than to be referred to the juvenile justice system, compared to females and White youth.
Return to Top

Mental Disorders

Table 2 shows the proportion of youth in the clinical range on each of the narrow-band syndromes. Considering the seven measures of psychopathology, 70% of the youth experienced clinical levels in at least one area. Forty-one percent of youth manifested clinically-significant levels of aggressiveness. However, more youth reported serious delinquency (47%) than any other type of problem. All nine syndromes considered, 80% of the sample reported clinical levels in at least one problem area 3.
Co-occurrence of Delinquency and Mental Illness
Table 3 presents the zero-order correlations between the delinquency scale score and the seven psychopathology scale scores. The data show higher levels of delinquency associated with higher levels of psychopathology. While all the relationships are statistically significant ($p < .01$), the magnitude of the correlations is rather modest. Nearly all are .4 or less. In general, these findings suggest a moderate relationship between levels of delinquency and psychopathology.

Another way to assess co-occurrence of delinquency and mental disorder is to identify the proportion of youth with clinical levels of symptomatology in both areas. Table 4 shows that 39% of the youth experienced clinical levels of delinquency-related problems as well as clinical levels in at least one of the seven areas of psychopathology. At the same time, a nearly equal proportion (31%) had more focused problems of the type mental health services were traditionally designed to address.

A closer view of these data further highlights the nature of the relationship between delinquency and mental disorder. Among youth with serious levels of psychopathology (70%), 56% also indicated a clinically-significant level of delinquency. The problems of the other 44% remained more circumscribed to some type of mental disorder only. The picture changes considerably, though, when one considers those youth referred for services with serious delinquency-related problems (47%). Among these youth, a large majority (83%) also had clinically-significant psychopathology. The pervasiveness of these youth's problems is further indicated by the fact that youth with clinically-significant delinquency problems reported clinical levels in an average of 3.3 areas of psychopathology while those with a nonclinical delinquency profile experienced serious levels in 1.6 areas of psychopathology. So, while

delinquency and mental disorder are only moderately related, when delinquency occurs, it is very likely to be accompanied by severe psychopathology in multiple problem areas.
Return to Top

Discussion

The co-occurrence of mental illness and delinquency, specifically, raises special concerns for the mental health field. The large and growing numbers of comorbid youthful offenders within the mental health system, and the pervasiveness of their prob-lems, challenge the way we develop, structure, and deliver services to this group of youth. Programs within the mental health system have been traditionally designed for troubled youth, not troublesome youth. The findings presented here suggest that clinicians may need to anticipate that over half of their clients may not only have some psychopathology, but may also be disruptive, perhaps violent, and difficult to control.

The task of providing appropriate care is made more difficult by the fact that relatively large proportions of youth in the mental health system have been involved in the juvenile justice system as well. Developing a service system for troubled and troubling youth requires integration of more than the typical child-helping systems (e.g., education, social services). It also requires incorporating the juvenile justice system, a system that unlike other child-serving systems, has increasingly responded punitively rather than rehabilitatively toward youth (Schwartz, 1989). Problems of system integration and the development of effective services extend beyond these philosophical differences between systems. Pragmatic issues of system boundaries, perceived scope of responsibility, and financing structures continue to thwart efforts to integrate service systems for children and adolescents (Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993; Fagan, 1991).

The overlap between mental disorder and delinquency, indicated by the findings here, also calls into question the criteria for placing youth in either the mental health or juvenile justice system. Some evidence suggests, for example, that personal traits such as sex and race predict system placement more reliably than psychopathology (Westendorp, Brink, Robertson, & Ortiz, 1986). The juvenile justice system has long been prey to charges of discrimination. The mental health system, with some historical exceptions, has been less a target for such claims. This situation may change as the types of problems that define youth in need of mental health treatment and eligibility for reimbursement expand, such as in the case of substance use (Schwartz, Jackson-Beeck, & Anderson, 1984; Staples and Warren, 1988).

The development of a service system that can adequately attend to the needs of youth who demonstrate levels of delinquency-related problems more severe than 95% of their peers in the general population remains a serious challenge for policy makers, program planners, and clinicians. Moreover, we must also recognize that the juvenile justice system must be counted among the institutional actors that represent a comprehensive system of care for children and adolescents (Stroul and Friedman, 1986). Efforts to develop this integrated system, finally, cannot be divorced from larger issues of social justice and equity.
Return to Top

References

Achenbach, T. M. (1991). Manual for the Child Behavior Checklist and 1991 Profile. Burlington, VT: University of Vermont, Department of Psychiatry.
Achenbach, T. M. & Edelbrock, C. (1987). Manual for the Youth Self-Report and Profile. Burlington, VT: University of Vermont, Department of Psychiatry.

Bickman, L., Guthrie, P., Foster, E. M., Lambert, E. W., Summerfelt, W. T., Breda, C., & Heflinger, CA. (1995). Evaluating managed mental health services: The Fort Bragg experiment. Plenum Publishing Corp.
Carnegie Corporation Report. 1994.

Duchnowski, A., Johnson, M., Hall, K., Kutash, K., & Friedman, R. (1993). The alternatives to

residential treatment study: initial findings. Journal of Emotional and Behavioral Disorders,1 (1), 17-26.

Elliott, D., Huizinga, D., & Menard, S. (1989). Multiple problem youth: Delinquency, substance use, and mental health problems. Springer-Verlag New York Inc.
Fagan, J., (1991). Community-based treatment for mentally disordered juvenile offenders. Journal of Clinical Child Psychology ,20 (1), 42-50.

Schwartz, I. (1989). Injustice for children. Lexington, MA: D. C. Heath.
Schwartz, I., Jackson-Beeck, M., & Anderson, R. (1984). The "hidden" system of juvenile control. Crime and Delinquency, 30 (3), 509-520.

Staples, W. G., & Warren, C. (1988). Mental health and adolescent social control. Research in Law, Deviance, and Social Control, 9 ,113-126.

Stroul, B. A. & Friedman, R. (1986). A system of care for children and youth with severe emotional disturbances (rev ed.). Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

U.S. Department of Justice. (1991). Crime in the U.S.: Uniform Crime Reports. U.S. Government Printing Office. Washington, D.C.

Westendorp, F., Brink, K. L., Robertson, M. K., & Ortiz, I. E. (1986). Variables which differentiate placement of adolescents into juvenile justice or mental health systems. Adolescence 21 23-37.
Return to Top

Carolyn S. Breda, Ph.D.
Research Associate
Center for Mental Health Policy
Vanderbilt University
1207 18th Ave. South,
Nashville, TN 37212
615/322-8435 Fax: 615/322-7049
E-Mail: BREDACS@CTRVAX.VANDERBILT.EDU

This research was supported by the U.S. Army Health Services Command (DADA 10-89-C-0013) as a subcontract from the North Carolina Department of Human Resources/Division of Mental Health, Developmental Disabilities and Substance Abuse Services, and a grant to Dr. Leonard Bickman (RO1MH-46136-01) from the National Institute of Mental Health.

1 The delinquency syndrome scale is based on 13 items, 7 of which refer to legally proscribed behavior (e.g., running away, arson, stealing at home, stealing outside the home, truancy, substance use, and vandalism). Three other items refer to nondelinquent behavior (swears, lies/cheats, associates with troublemakers). Three others refer to attitudes or thought processes (feels no guilt after wrongdoing, prefers older companions, and thinks about sex too much). Thus, the delinquency measure used in this research is not based solely on delinquent conduct. However, empirical analyses have repeatedly found that these thirteen items correlate and load on a single "delinquency" factor (Achenbach, 1991). Further, preliminary analyses of the FBEP data show that over 80% of youth with clinical levels of delinquency also report engaging in legally proscribed behavior. These findings support the validity of using the delinquency syndrome score as a surrogate for delinquency.
2 For this research, the author does not consider the aggressiveness syndrome a measure of psychopathology. It more resembles delinquency: it includes three items that refer to legally proscribed behavior (i.e., destroying others' property, fighting, and physically attacking other people) and highly correlates with delinquency (r = .71).
3 That 20% did not report a clinical level on any of the CBCL measures does not necessarily mean some youth were receiving mental health services inappropriately (Achenbach, 1991).

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Assessing The Mental Health of Adolescents in the Mental Health and Juvenile Justice Systems

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Introduction/Purpose

The purpose of the present study is to describe the mental health functioning of youth involved in the mental health and juvenile justice systems. Self-report information is derived from the Millon Adolescent Clinical Inventory (MACI; Millon, 1993), which gives diagnostic impressions and personality descriptions, as well as from the Trauma Symptom Checklist for Children (TSCC; Briere, 1989), which gives information about trauma related symptoms and post-trauma functioning. Caregivers report impressions of behavior and emotional functioning using the Child Behavior Checklist (CBCL ; Achenbach, 1991).
Return to Top

Method/Procedure

Two self-report instruments&shyp;the MACI and TSCC&shyp; were administered to 13 male adolescents incarcerated in a juvenile justice facility (Group I) and 13 male adolescents served by intensive-in-home wrap-around services (Group II). The CBCL was completed by caregivers for both groups.

There were no statistically significant differences in age or race between the two groups. The mean age for the two groups was 15.5 years for Group I and 14.5 years for Group II ($t = 0.23$, $df = 24$, $p = NS$) with a total range of 13 to 17 years. The racial distribution was: 3 African-American, 10 Caucasian for Group I and 1 African-American, 12 Caucasian for Group II ($c2 > 0.295$, $p > .05$).

Additionally, a demographic coding sheet was completed on all subjects by the investigators. Demographic data was obtained from juvenile justice and mental health databases which included child, family and academic information. Youth were comparable on age, race, gender, and on mental health as well as juvenile justice issues.
Return to Top

Results

Results on the MACI suggest that youth in the juvenile justice system expressed significantly more mental health concerns than did the youth in the mental health system. Overall, youth in Group I displayed elevations on 11 scales while those in Group II were elevated on 8 scales. Five areas of significant differences between the two groups were found. Significant differences were in the direction of Group I. (see Figure 1) Significantly elevated scores on MACI scales included Doleful, Desirability, Childhood Abuse, Substance Abuse Proneness and Anxious Feeling.

It is also important to note that no differences were found between the groups on MACI scales measuring Depressive Affect, Suicidality or Delinquent Predisposition. Also, groups were comparable on the TSCC scales measuring Anxiety, Depression, Post-traumatic Stress, Sexual Concerns, Dissociation and Anger.

Many significant differences were found between the caregivers' ratings on the CBCL for the two groups. However, the differences are difficult to interpret. The validity of observations reported for Group I are questionable. Observations for Group II showed a strong relationship to youth-reported concerns on the MACI.
Return to Top

Implications

The present study identifies the mental health concerns of a small number of youth involved in the mental health and juvenile justice systems. The study directly measures the concerns of youth in each system. Differences as well as similarities describe mental health concerns in the juvenile justice involved youth. Understanding the breadth of the juvenile justice involved youth's mental health needs may facilitate the development of an array of services addressing the physical, emotional, social and educational needs of the adolescent and his/her family.

Two major shortcomings of the study are its small sample size and possible group difference resulting from subject selection procedures. Youth in the juvenile justice group resided in an institution, while youth in the mental health group resided at home and were served by community-based interventions. The mental health group is the most comparable group available in the public mental health system in Ohio, but group differences resulting from the effect of institutionalization may account for the study's findings. Further cross-system work is needed.
Return to Top

References

Achenbach, T. M. (1991). Child Behavior Checklist. Burlington, VT: The University of Vermont Department of Psychiatry.

Briere, J. (1989). Trauma Symptom Checklist for Children. Unpublished Psychological Test.

Millon, T. (1993). Millon Adolescent Clinical Inventory. Minneapolis, MN: National Computer Systems, Inc.
Return to Top

Jane Timmons-Mitchell, Ph.D.
Assistant Professor, Department of Psychiatry
Director, Child Abuse Treatment Program
Norma Jeanne Boyd, Ph.D.,
Thomas M. Evans, Ph.D.
Post-Doctoral Residents in Child Psychiatry
Case Western Reserve University School of Medicine
Department of Psychiatry, Hanna Pavilion
University Hospitals of Cleveland
11100 Euclid Avenue
Cleveland, OH 44106
216/844-5461

Christie Brown, B.A.
Coordinator, Child Abuse Treatment Program

University Hospitals of Cleveland
Department of Psychiatry, Hanna Pavilion
University Hospitals of Cleveland
11100 Euclid Avenue
Cleveland, OH 44106
216/844-5461

Lee A. Underwood, Psy.D.
Director of Psychological Services
Ohio Department of Youth Services
51 North High Street, Suite 501
Columbus, OH 43266-0582
216/466-0586

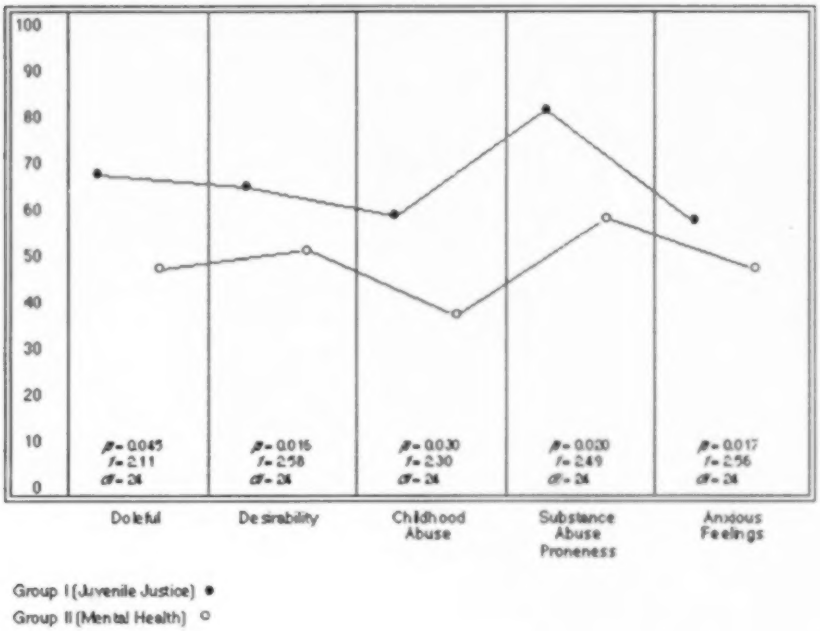
Charlie Johnston, B.A.
Chief Executive Officer
Sagamore Hills Children's Psychiatric Hospital
Medina/Ashland Child & Family Intervention Team
3076 Remson Road
Medina, OH 44256
216/722-0750

S. Charles Schulz, M.D.
Professor and Chairman, Department of Psychiatry
Case Western Reserve University School of Medicine
Department of Psychiatry, Hanna Pavilion
University Hospitals of Cleveland
11100 Euclid Avenue
Cleveland, OH 44106
216/844-5461
Return to Top

[Home] [Search] [Index]

Figure 1
Return to Article

Figure 1
MACI Significant Differences



BEST COPY AVAILABLE

8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Psychopathology and Symptomatology in Incarcerated versus Hospitalized Youth

Authors

Introduction Method Results Discussion References
Return to Table of Contents

Background

The problems of juvenile crime and the incarceration of youth are receiving increasing attention nationally. These are particularly critical problems in South Carolina, which already has the highest rate of incarceration of any region in the free world (Corrections Compendium, 1991; Fowler, 1991). The South Carolina Department of Juvenile Justice (DJJ) has a daily census of 800 to 1000 youth incarcerated in its facilities in Columbia and serves over 3000 youth annually. It is currently facing a lawsuit in federal district court involving overcrowding of its facilities and the care of juvenile offenders that have emotional disturbances or mental illness.

The fact that youth with mental illness are being incarcerated at all brings up serious concerns about the failure of community services designed to prevent such outcomes (Duchnowski, Johnson, Hall, Kutash, & Friedman, 1993). The lack of community-based and preventive mental health services for youth, particularly in rural areas, allows many youth with emotional or mental disorders to go undetected and untreated to the point that they suffer from disruptive behavioral symptoms and come to the attention of juvenile authorities and family courts. These factors may account for the over-representation of African-American youth in the incarcerated juvenile population (Cohen, Parmelee, Irwin, Weisz, Howard, Purcell, & Best, 1990). There may be a number of factors involved in the over-representation of minority youth in incarcerated populations including: the failure of mental health and social services to address the needs of minority youth (Mason & Gibbs, 1992) and biases in assessment (Fabrega, Ulrich, & Mezzich, 1993) which may predispose the entry of minority youth into the juvenile correctional system.

To date, there have been no systematic studies in the U. S. addressing the problem of incarceration of youth with emotional disorders/mental illness. The few studies conducted have not used systematic diagnostic instruments to evaluate such disorders and have not examined factors leading to incarceration. Those conducted so far indicate that a major proportion of incarcerated juvenile offenders have significant mental/emotional disorders (Hollender & Turner, 1985; McManus, Alessi, Grapentine, & Brickman, 1984).

Specific Aims
This project addresses a number of important questions underlying the incarceration of youth with mental/emotional disorders. These include: (1) What is the prevalence of major DSM III-R diagnoses amongst incarcerated versus hospitalized youth? (2) What is the symptomatic prevalence (mean symptom count) across the two groups? (3) What are the levels of behavioral symptomatology (as measured by CBCL and YSR) across the two study groups?
Return to Top

Methodology

Subjects
We recruited youth from the midlands region of South Carolina, ages 13-17, including youth hospitalized at the William S. Hall Psychiatric Institute (which serves youth from most of the state) and incarcerated youth recruited from DJJ in Columbia. Hospitalized youth were randomly selected from new admissions, while incarcerated youth were randomly selected from institutional rosters. The counties included in the study represent a balance of rural and urban populations. Youth with an IQ of 65 or below were excluded from the study. Sample demographics were as follows: mean age = 14.9 (hosp.), 14.4 (DJJ); gender = 55% male (hosp.), 94% male (DJJ);
race = 52% African-American and 48% Caucasian (hosp.),
68% African-American and 32% Caucasian (DJJ).

Instruments
DISC-PC, version 2.3 (Diagnostic Interview Schedule for Children). This structured diagnostic interview was used to determine diagnoses as well as symptoms of mental/emotional disorders. It was administered by psychiatric social workers, nurses and physicians (Shaffer, et al., 1993).
Child Behavior Checklist. This instrument was used to obtain parent ratings of behavioral and emotional symptoms (Achenbach, 1991).

Services History Form. The Services History Form was developed and administered as a standard instrument, completed by the parent to document and code categories of health, mental health (outpatient and acute hospitalization), residential, educational, social, and volunteer (Boy/Girl Scouts, Big Brother/Sister, etc.) services provided for each youth. This instrument was patterned after that described by Hinkle (1992), in use at the South Carolina Continuum of Care. Parents were asked to rate the value of this service, the age of the youth when the service was used, the service's duration, and frequency.

Procedure
Youth and their parents/guardians were recruited to participate in the study and written consents were obtained. The parent behavior rating scale (CBCL) was completed either in person or by mail. If the parents were unable to read they were provided assistance. The youth were then interviewed by trained professionals (clinical psychiatric social workers and nurses).
Return to Top

Results

We are currently reporting on preliminary findings based on 31 hospitalized and 31 incarcerated youth studied to date. On the DISC 2.3, we found that 79% of the hospitalized youth and 71% of the incarcerated youth met diagnostic criteria for at least one disorder. There was a high rate of comorbidity in both samples, with a mean of 3.1 diagnoses per youth in the hospital sample and 2.4 diagnoses in the incarcerated sample&shyp;these differences in rates between the two samples were not statistically significant ($t = 0.93$, $p > 0.20$). Levels of symptomatology were also quite high in both samples, with a mean of 43.8 positive symptoms in the hospital sample and 30.4 symptoms in the incarcerated sample&shyp;a difference of marginal significance ($t = 1.95$, $p < .10$).

Using the CBCL, we found greater differences between the two groups. The mean total T score (72.8), the mean internalizing T score (70.4), and the mean externalizing T score for the hospital sample (70.0) were higher than for the incarcerated sample (mean T total = 61.8; mean internal T = 56.8, mean external T = 63.2; total T: $t = 4.62$, $p < .001$; internal T: $t = 4.84$, $p < .001$; external T: $t = 2.77$, $p < .01$). In the hospital sample, 93% met the 60+ cutpoint total problem T score suggested by Achenbach (1991). In the incarcerated group, 60% met the 60+ cutpoint. Additional analyses along racial/ethnic lines indicate that hospitalized African-American youth (N = 15) had much higher mean number of diagnoses (3.56), mean symptom counts (50.8) and percent caseness (88%) than Caucasian youth who were hospitalized (N = 15, mean dx. = 2.46, mean sx. ct. = 35.3, and percent caseness = 69%); while incarcerated African-American youth had slightly lower levels of psychopathology (N = 21, mean dx. = 2.21, mean sx. = 29.2, percent caseness = 69%).

The overall levels of service utilization were found to be somewhat higher in hospitalized (mean = 7.90)

versus incarcerated youth (mean = 5.55; t = 1.76, p < .20). Levels of educational and volunteer services were similar (hospitalized youth: mean educational services = 1.63, mean volunteer services = 0.90; Incarcerated youth: mean educational services = 1.32, t = 1.49, p < .20, mean volunteer services = 0.71, t = 0.60, p > .20&shyp;non significant). Incarcerated youth actually had higher levels of previous out-of-home residential services (residential, foster care, group home; mean = 1.32) as compared to hospitalized youth (mean = 0.71; t = 2.22, p < .05). However, they had lower levels of previous mental health services (mean = 1.19) as compared to hospitalized youth (mean = 2.46; t = 3.05, p < .01). In examining cross-ethnic differences, we found that African-American hospitalized youth used equal levels of mental health services as Caucasian youth, but had higher levels of special school services (53% using additional school services) as opposed to Caucasian hospitalized youth (20%), higher levels of residential services (mean = 0.87) than hospitalized Caucasian (mean = 0.47), but equal residential services as incarcerated African-American youth (mean = 1.00).
Return to Top

Conclusions

Levels of psychopathology and symptomatology are lower in incarcerated youth as compared to hospitalized youth. However, their levels of symptomatology and psychopathology are quite significant as compared to expected general population rates. This strongly indicates the appropriateness of high levels of mental health services to address the needs of incarcerated youth. In addition, the findings do not support the common assumption that incarcerated youth receive significantly fewer services than other youth. However, it is important to note that incarcerated youth have received lower levels of mental health services while receiving higher levels of out-of-home services. A tentative hypothesis coming out of our findings is that more frequent use of outpatient mental health services, perhaps at a younger age, might result in youth being served more readily in the mental health versus the juvenile justice system. Another tentative hypothesis is that minority youth may travel a parallel service pathway from school or social services into the juvenile justice system which does not often intersect with mental health services. Continued analysis on the complete cohort will investigate racial/ethnic factors in service utilization and age of entry into the mental health system across the two groups.
Return to Top

References

Achenbach, T. (1991). Interpretive Guide for the 1991 CBCL / 4-18, YSR, and TRF Profiles. Burlington, VT: University of Vermont.

Cohen, R., Parmelee, D., Irwin, L., Weisz, J., Howard, P., Purcell, P., & Best, A. (1990). Characteristics of children and adolescents in a psychiatric hospital and a correctional facility. Journal of the American Academy of Child and Adolescent Psychiatry, 29(6), 909-913.

Duchnowski, A., Johnson, M., Hall, K., Kutash, K., & Friedman, R. (1993). The alternatives to residential treatment study: Initial findings. Journal of Behavioral and Emotional Disorder, 1(1), 17-26.

Fabrega, H., Ulrich, R., & Mezzich, J. (1993). Do Caucasian and Black adolescents differ at psychiatric intake? Journal of the American Academy of Child and Adolescent Psychiatry, 32(2), 407-413.

Fowler, L. T. (November, 1991). Trends data, South Carolina. Department of Corrections Division of Resource and Information Management.

Hinkle, K. (1992). Utilization pathways: Implications for system of care services. In K. Kutash, C. J. Liberton, A. Algarin & R. M. Friedman (Eds.) Proceedings of the 5th Annual Research Conference, A System of Care for Children's Mental Health: Expanding the Research Base. (pp. 39-45). Tampa, FL: University of South Florida, Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Hollender, H. & Turner, F. (1985). Characteristics of incarcerated delinquents: Relationship between developmental disorders, environmental and family factors, and patterns of offense and recidivism. Journal of the American Academy of Child and Adolescent Psychiatry, 24(2), 221-226.

Mason, M. & Gibbs, J. T. (1992). Patterns of adolescent psychiatric hospitalization: implications for social policy. American Journal of Orthopsychiatry, 62(3), 447-457.

McManus, M., Alessi, N., Grapentine, W., & Brickman, A. (1984). Psychiatric disturbance in serious delinquents. Journal of the American Academy of Child and Adolescent Psychiatry, 23(5), 602-615.

Shaffer, D. Schwab-Stone, M., Fisher P., Cohen, P., Piacentini, J., Davies, M., Conners, K., & Regier, D. (1993). The Diagnostic Interview Schedule for Children&shyp;Revised (DISC-R): In Preparation, Field Testing, Interrater Reliability and Acceptability. Journal of the American Academy of Child and Adolescent Psychiatry 32 (3): 643-650.
U.S. Incarceration Rate Leads the World. Corrections Compendium, January, 1991
Return to Top

Andres J. Pumariega, M.D.
Professor and Vice-Chairman
Department of Neuropsychiatry & Behavioral Sciences
University of South Carolina, and
William S. Hall Psychiatric Institute
South Carolina Department of
Mental Health
1800 Columbia Dr., P.O. Box 202
Columbia, SC 29202
803/734-7170 Fax: 803/734-7894

Lanette Atkins, M.D.
Fellow in Child & Adolescent Psychiatry
Department of Neuropsychiatry & Behavioral Sciences
University of South Carolina, and
William S. Hall Psychiatric Institute,
South Carolina Department
of Mental Health
1800 Columbia Dr., P.O. Box 202
Columbia, SC 29202
803/734-7170 Fax: 803/734-7894

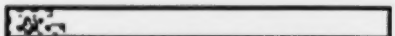
Sally Hardin, Ph.D.
Professor of Nursing
University of Massachusetts
Worcester, MA

Larry Montgomery, M.D.
Chief of Forensic Inpatient Services
William S. Hall Psychiatric Institute
South Carolina Department of
Mental Health
1800 Columbia Dr., P.O. Box 202
Columbia, SC 29202
803/734-7244 Fax: 803/734-0791

Timothy Kowalski, M.D.
University of South Carolina, and
William S. Hall Psychiatric Institute,

South Carolina Department of
Mental Health
1800 Columbia Dr., P.O. Box 202
Columbia, SC 29202

Donna Culley, Ph.D
Chief of Psychology Services
South Carolina Department of
Juvenile Justice
Columbia, SC 29210
803/734-7244 Fax: 803/734-0791
Return to Top



8th Annual Research & Training Center Conference Proceedings, Dept of Child and Family Studies, Florida Mental Health Institute, University of South Florida,1996

Boot Camp: Is It Working?

Authors

Introduction Method Results Discussion
Return to Table of Contents

Background

The Pinellas Boot Camp Initiative in Pinellas County, Florida, is a complex juvenile justice program characterized by a high degree of interagency collaboration, strong involvement of community leaders and policy makers, and an emphasis on family involvement. It is the first program of its kind in Pinellas County and one of the first programs in the country to utilize the boot camp model for juvenile offenders.

The interagency service delivery model was designed to address concerns about increases in juvenile crime and recidivism with innovative solutions. Partners in this effort include the Pinellas County Sheriff's Department, the Pinellas County School Board, District V Juvenile Justice Program (JJ), Eckerd Family Youth Alternatives (EFYA), and the Juvenile Welfare Board of Pinellas County (JWB). The Advisory Group includes leadership from the County Commission, Office of Justice Coordination, and the Judicial system. The Juvenile Welfare Board's Research & Development Center is conducting a comprehensive evaluation of the Initiative to determine the profiles of the youth for whom this program is effective in terms of recidivism, their personal growth and public safety.

The Pinellas County Boot Camp Initiative serves juvenile offenders (ages 14-18) and their families. Screening criteria were established by the Juvenile Justice Act. Eligible youth are those committed to level 6 and level 8 programs who are physically and mentally able to participate. The program includes a four month residential commitment phase (Pinellas County Boot Camp), where youth confined to the Boot Camp undergo intensive physical training, education and counseling; an eight month intensive aftercare commitment phase (Eckerd Leadership Program), where youth continue activities which now include restitution, career development, job training and employment in an increasingly less structured setting; and twelve months of voluntary follow-up. Family support services are provided to families of recruits during the entire Initiative.

The Pinellas County Boot Camp serves the Juvenile Justice West commitment service region, which includes Pinellas, Pasco, Hillsborough, Polk, Highlands, Hardy, Manatee, Sarasota, Lee and Collier Counties. The Eckerd Leadership Program (ELP) serves only youth and families living in Pinellas County. Recruits from other counties are transferred to aftercare programs in their county of origin.
Return to Top

Method

A comprehensive interagency data base and data management agreement were developed during the start-up year. The data base will be utilized in 1995-96 to track program outcomes and look for predictive factors, such as individual youth characteristics or patterns of offense history, which may be associated with successful program completion and positive outcomes. Other assessments have included personal interviews with recruits and staff at both facilities, timed observations, and regular data

collection from all collaborators about the youth and their progress in the Initiative.

The creation of the new Florida Department of Juvenile Justice and associated changes in legislation and funding will have long lasting impact on many aspects of the Boot Camp Initiative. The most significant short-term impact was a delay in funding for full implementation of the Aftercare phase.

Funding for the residential program at the Boot Camp was not affected when responsibility was transferred to the new Department on July 1, 1994. In addition, the Boot Camp, which opened in November, 1993, was past the start-up period with most planned interventions in place when the change occurred. By contrast, the ELP Aftercare program, which opened on March 29, 1994 with start up funds from the Juvenile Welfare Board, did not have an established contract with the state's Department of Health and Rehabilitative Services to transfer to the Department of Juvenile Justice on July 1, 1994. Although the day program and some support services were provided, evening and weekend hours and the hiring of additional staff at the Aftercare site were delayed through the Fall of 1994. This resulted in less intense supervision of youth during the community phase than had been planned, and delayed implementation of some Aftercare programs and services. Full funding has now been approved, and the Aftercare component is moving towards full implementation.

The collaborative program model is designed to provide comprehensive services to respond to complex needs. Program strategies include provision of structure and discipline combined with appropriate role modeling, individualized planning, supervision and family involvement to increase youths' pro-social behavior and reduce delinquency. Interagency communication and coordination are viewed by all participating agencies as essential to successful outcomes. Progress has been made to establish continuity and commonalties among all program components.

An interagency planning and evaluation process has supported this effort. Continued attention to integration of program components is recommended, as is periodic interagency review of the conceptual framework and program goals.

Return to Top

Findings

Data collected during the first year of the program show that youth admitted to the Boot Camp have diverse needs. Many have experienced disruptions in family life and have had poor school adjustment. More than half of all recruits have special education needs. Many have had several prior referrals into the juvenile justice system and have been in other commitment programs. Appropriate home placement during aftercare has been an issue for several youth, especially those who had been living in foster care or other non-family settings prior to commitment. Comprehensive evaluation of individual risks and needs has not always been available prior to placement in the residential Boot Camp program.

Program completion data are available for all recruits admitted to Pinellas County Boot Camp, and for Pinellas County youth who transitioned to ELP Aftercare. Completion data is not available for youth who reside in other counties but will be included in the next semi-annual report. Recidivism rates and other outcome data were not computed because some phases of the program have been in operation for less than a year. Preliminary outcome data will be included in the semi-annual report. Because of changes in program eligibility, program modifications during the start up period and unexpected delays in implementing some aspects of the program, results for the first several platoons will be analyzed separately.

Return to Top

Discussion

Other evaluation issues to be addressed during the next period include utilization and impact of

"recycling" youth who engage in risk taking behavior back to Boot Camp from aftercare, criteria for "readiness" of youth to transition from Boot Camp to a community setting and analysis of educational progress and outcomes during all program phases.

Results to date are inconclusive. However, it is the expectation of the researchers that the next report on this Initiative will have preliminary information about the profiles of youth who most benefit from this program.

Return to Top

Judy A. Hall, Ph.D., A.C.S.W.
Director, Research & Development Center
Judith L. Kugler, M.B.A.
Program Consultant, Research & Development Center
Juvenile Welfare Board of Pinellas County, FL
4140 49th St. N
St. Petersburg, FL 33798
813/521-1853 Fax: 813/528-0803

Return to Top